

PRESENTENCE INVESTIGATION PERSONAL DATA INFORMATION

Date: _____ Name: _____ Alias/AKA: _____

Date of Birth: _____ Citizenship: _____ Alien Number: _____
Attorney's name: _____ Alien Status: _____

CURRENT OFFENSE:

Did you have a weapon?: ☐ Yes ☐ No Type of weapon: _____

Are you guilty of the offense you just went to court for?: ☐ Yes ☐ No

Do you have any pending charges?: ☐ Yes ☐ No What for?: _____
City/County/State: _____

CRIMINAL HISTORY:

Were you ever arrested as a **juvenile**?: ☐ Yes ☐ No

If yes: Number of Convictions: _____ Number of Arrests: _____ Number of Probations: _____

Do you have an **adult** criminal history?: ☐ Yes ☐ No

Age at first conviction: _____

Do you have a history of gang affiliation? ☐ Yes ☐ No Type: _____

MEDICAL HISTORY:

Have you ever been treated at a psychiatric hospital?: ☐ Yes ☐ No Where?: _____

At an MHMR Facility?: ☐ Yes ☐ No Where?: _____

List any physical/medical impairments: _____

Are you taking any medications, including psychotropic?: ☐ Yes ☐ No

If Yes, list: _____

Have you ever attempted suicide?: ☐ Yes ☐ No If yes, date of last attempt: _____

EDUCATION/JOB SKILLS:

High School Diploma: ☐ Yes ☐ No GED: ☐ Yes ☐ No

List any special classes you were in while in school: _____

Have you attended some college?: ☐ Yes ☐ No College Graduate: ☐ Yes ☐ No

Vocational training: ☐ Yes ☐ No Type: _____

Job skills: _____ Principal Language: _____ Can you read?: ☐ Yes ☐ No

EMPLOYMENT:

Current/Most recent employer:_____

Date Employed:_____ Job Type:_____

If unemployed, how long (months/years):_____

Reason for leaving:_____

Income sources/amount:_____

Are you paying child support? ☐ Yes ☐ No**ALCOHOL/DRUG HISTORY:**Indicate the type and frequency of drug(s) use **as it applies to your entire life** by placing an "X" in the appropriate space.

	Daily	Weekly	Monthly	Occasionally	Age 1 st Used	Date Last Used	Denied Use
1. Alcohol/Beer							
How many drinks – shots or beers – do you have in one sitting? <input type="checkbox"/> 1-4 drinks <input type="checkbox"/> 5-8 <input type="checkbox"/> 9 or more							
2. Cocaine							
3. Crack							
4. Heroin							
5. Marijuana							
6. Amphet/ Methamphetamine							
7. LSD							
8. PCP							
9. Inhalants							
10. Other drugs:							

Indicate the type and number of incidents of drug counseling or treatment received:

_____ DWI education	_____ AA/NA, etc.
_____ Individual counseling	_____ Drug education classes
_____ Out-patient group counseling	_____ Residential treatment

Were you under the influence of drugs/alcohol at the time of the offense? ☐ Y ☐ NWas the offense committed to buy drugs/alcohol? ☐ Y ☐ N

Last drug use:_____ Drug of Choice: _____

History of IV drug use? ☐ Y ☐ N**AFFIDAVIT**

I swear the above answers are true.

Defendant

8/14/07